

Department of Vermont Health Access 312 Hurricane Lane, Suite 201

Williston, VT 05495 www.dvha.vermont.gov [phone] (802)879-5903 [fax] (802)879-5963

VERMONT MEDICAID ADMISSION NOTIFICATION FORM FOR OUT-OF-STATE HOSPITAL PSYCHIATRIC INPATIENT SERVICES

(Including Border Hospitals for Children and Adolescents)

Instructions:

The following information and justification must be provided to the Department of Vermont Health Access (DVHA) (**fax: 802-879-5963**) within 24 hours or next business day of a hospital admission. Copies of the initial nursing assessment and treatment plan which include the clinical justification for admission, diagnosis and medications can be substituted for the assessment narrative.

	Date of Request		
Patient Name (Last)	(First	<u> </u>	
Address			
Medicaid ID Number	_ Date of Birth	Gender M F (circle one)	
(For children) Parent/Guardian Name_		DCF Custody? Y N (circle or	ne)
If in DCF custody, name of social work	er assigned to case, o	listrict and telephone number	
Is patient receiving mental health service			
If yes, name of provider			
Referral Source			
	Facility Info	rmation Medicaid Provider Number	
Address		Telephone Number	_
Contact Person for Concurrent Review_		Fax Number	_
Telephone Number	Ext		
		chiatric inpatient admission, diagnosis and r	nedications
(use additional sheets if necessary or att			nedications
			nedications